House Insurance and Banking Subcommittee Am. #1

Amendment No._____

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Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 2165* **House Bill No. 2355**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-2360, is amended by deleting the section and substituting the following:

(a)

(1) As used in this section, unless the context otherwise requires:

(A) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit;

(B) "Annual limit" means a dollar limitation on the total amount that may be paid for benefits in a twelve-month period under a health plan with respect to an individual or other coverage unit;

(C) "Classification of benefits" means inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits. These classifications of benefits are the only classifications that may be used except that there may be sub-classifications within both outpatient classifications differentiating office visits from other outpatient items and services, including outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items;

(D) "Financial requirement" includes deductibles, copayments,

coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit;

(E) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, other plans administered by the state government, or any certificate issued under the policies, contracts, or plans;

(F) "Health insurance carrier" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner of commerce and insurance, that contracts with healthcare providers in connection with a plan of health insurance, health benefits, or health services;

(G) "Mental health or alcoholism or drug dependency benefits" means benefits for the treatment of any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;

(H) "Non-quantitative treatment limitations," or "NQTLs," are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to:

(i) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or

investigative;

(ii) Formulary design for prescription drugs;

(iii) Tier design for plans with multiple network tiers, including preferred providers and participating providers, and network tier design;

(iv) Standards for provider admission to participate in a network, including reimbursement rates;

(v) Plan methods for determining usual, customary, and reasonable charges;

(vi) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, that are also known as fail-first policies or step therapy protocols;

(vii) Exclusions based on failure to complete a course of treatment;

(viii) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(ix) In- and out-of-network geographic limitations;

(x) Standards for providing access to out-of-network providers;

(xi) Limitations on inpatient services for situations where the participant is a threat to self or others;

(xii) Exclusions for court-ordered and involuntary holds;

(xiii) Experimental treatment limitations;

(xiv) Service coding;

(xv) Exclusions for services provided by clinical social

workers;

(xvi) Network adequacy; and

(xvii) Provider reimbursement rates, including rates of reimbursement for mental health and substance abuse services in primary care;

(I) "Predominant" means application to more than one-half (1/2) of such type of limit or requirement;

(J) "Substantially all" means application to at least two-thirds (2/3) of all medical or surgical benefits in a classification; and

(K) "Treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(2) In addition to any other requirement of law concerning coverage of mental health or mental illness benefits or alcoholism or drug dependency benefits, including, but not limited to, §§ 56-7-2601 and 56-7-2602, any individual or group health benefit plan issued by a health insurance carrier regulated pursuant to this title shall provide coverage for mental health or alcoholism or drug dependency services in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. No. 110-343) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

(b) Nothing in subsection (a) prohibits an employee health benefit plan, or a plan issuer offering an individual or group health plan from utilizing managed care practices for the delivery of benefits required under this section, as long as that for any utilization review or benefit determination for the treatment of alcoholism or drug dependence the clinical review criteria is the most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction

Medicine or other evidence-based clinical guidelines, such as those referenced by the federal substance abuse and mental health services administration (SAMHSA). No additional criteria other than in this subsection (b) may be used during utilization review or benefit determination for treatment of substance use disorders.

(c) The mandate to provide coverage for mental health services does not apply with respect to a group health plan if the application of the mandate to the plan results in an increase in the cost under the plan of more than one percent (1%). Documentation of the increase in cost must be filed with the department after twelve (12) months of experience. If the commissioner determines that the increase in cost is a result of the requirements of this section, the commissioner or the commissioner's designee shall issue a letter to the issuer of the plan stating that the plan does not have to comply with the mandate set out in this section. The issuer may appeal the letter as final agency action pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(d) The department of commerce and insurance shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. No. 110-343), this section, and §§ 56-7-2601 and 56-7-2602, which include:

(1) Ensuring compliance by individual and group health benefit plans;

(2) Detecting possible violations of the law by individual and group health benefit plans;

(3) Accepting, evaluating, and responding to complaints regarding such violations; and

(4) Maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint log regarding mental health or alcoholism or drug dependency coverage; provided, that individually identifiable information shall be excluded.

(e) Not later than January 31, 2020, the department shall issue a report to the general assembly and provide an educational presentation to the general assembly. The report and presentation shall:

(1) Discuss the methodology the department is using to check for compliance with the MHPAEA, and any federal regulations or guidance relating to the compliance and oversight of the MHPAEA, including 45 CFR 146.136;

(2) Discuss the methodology the department uses to check for compliance with this section and §§ 56-7-2601 and 56-7-2602;

(3) Identify market conduct examinations conducted or completed during the preceding twelve-month period regarding compliance with parity in mental health or alcoholism or drug dependency benefits under state and federal laws and summarize the results of such market conduct examinations. Individually identifiable information shall be excluded from the reports consistent with federal privacy protections, including, but not limited to, 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67. This discussion shall include:

(A) The number of market conduct examinations initiated and completed;

(B) The benefit classifications examined by each market conduct examination;

(C) The subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations; and

(D) A summary of the basis for the final decision rendered in each market conduct examination;

(4) Detail any educational or corrective actions the department of commerce and insurance has taken to ensure health benefit plan compliance with this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-

7-2602;

(5) Detail the department's educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law; and

(6) Describe how the department examines any provider or consumer complaints related to denials or restrictions to care for opioid use disorder treatment for possible violations of this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602, including complaints regarding, but not limited to:

(A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

(B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

(C) Denials of claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

(D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

(E) Step therapy requirements imposed before buprenorphine or naltrexone is approved; and

(F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine.

(f) The report issued pursuant to subsection (e) must be written in non-technical, readily understandable language and shall be made available to the public by posting

the report on the department's website and by other means as the department finds appropriate, provided that the department must redact the names of any health insurance carriers and any other entities that have entered into a contract with a health insurance carrier.

(g) Benefits under this section shall not be denied for care for confinement provided in a hospital owned or operated by this state that is especially intended for use in the diagnosis, care, and treatment of psychiatric, mental, or nervous disorders.

(h) Nothing in this section applies to accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, or other limited benefit hospital insurance policies.

(i) The commissioner is authorized to promulgate rules to effectuate the purposes of this section. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(j) Nothing in this section shall be construed as requiring the disclosure of any information that would violate 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

(a) Whenever the commissioner performs a market conduct examination of a health insurance carrier that issues a health benefit plan under the jurisdiction of the department of commerce and insurance for compliance with § 56-7-2360, the examination shall include, but not be limited to, the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental health or alcoholism or drug dependency benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(2) Identification of all non-quantitative treatment limitations (NQTLs) that

are applied to both mental health or alcoholism or drug dependency benefits and medical and surgical benefits; and

(3) The results of any analysis that may have been performed by a health insurance carrier that demonstrates that for the medical necessity criteria described in subdivision (a)(1) and for each NQTL identified in subdivision (a)(2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental health or alcoholism or drug dependency benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits. The results of the analysis may:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

(C) Identify and describe the methods and analyses used, including the results of any relevant analyses, to determine that the processes and strategies used to design each NQTL as written for mental health or alcoholism or drug dependency benefits are comparable to, and no more stringent than, the processes and strategies used to design each NQTL as written for medical and surgical benefits;

(D) Identify and describe the methods and analyses used, including the results of any relevant analyses, to determine that processes and strategies used to apply each NQTL in operation for mental health or alcoholism or drug dependency benefits are comparable

to, and no more stringent than, the processes or strategies used to apply each NQTL in operation for medical and surgical benefits;

(E) Disclose the specific findings and conclusions reached by the health insurance carrier that the results of any relevant analyses under this subsection indicate that the health insurance carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub .L. No. 110-343), and its implementing regulations, including 45 CFR 146.136 and any other applicable regulations; and

(F) Identify any other information necessary to clarify data provided in accordance with this section requested by the commissioner, including information that may be "proprietary" or have "commercial value." Any information submitted that is proprietary shall not be made a public record under title 10, chapter 7.

(b) The health insurance carrier's chief executive officer and chief medical officer shall sign a certification that affirms that the health insurance carrier has completed a comprehensive review of its administrative practices for the prior calendar year for compliance with the necessary provisions of this section, §§ 56-7-2601 and 56-7-2602, and the MHPAEA.

(c) Separate NQTLs that apply to mental health or alcohol or drug dependency benefits but do not apply to medical and surgical benefits within any classification of benefits are not permitted.

SECTION 3. This act shall take effect January 1, 2019, the public welfare requiring it. This act shall apply to policies and contracts entered into or renewed on and after January 1, 2019.

House Insurance and Banking Subcommittee Am. #1

Amendment No._____

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Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 1823 House Bill No. 1837*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 15, is amended by deleting the part and substituting instead the following:

71-5-1501.

(a) This part shall be known and may be cited as the "Ground Ambulance Service Provider Assessment Act."

(b) The intent of this part is to enhance EMS services and improve access to emergency medical pre-hospital care in this state.

71-5-1502.

As used in this part:

(1) "Ambulance provider" means a public or private ground-based ambulatory service, other than an ambulance service based on federal property, that bills for transports and has a base of operations within the state;

(2) "Assessment" means the medicaid ambulance provider assessment established by this part;

(3) "Bureau" means the bureau of TennCare;

(4) "Medicaid transport" means ground ambulance services specified in the Healthcare Common Procedure Coding System (HCPCS) under codes A0225, A0426, A0427, A0428, A0429, A0433, and A0434,

and paid by medicaid, as recorded by the managed care organization under contract to the bureau;

(5) "Net operating revenue" means all revenues, regardless of payer source, collected by ambulance providers for patient services excluding charity care or any other uncompensated patient services, in accordance with 42 CFR 433.68;

(6) "Office of emergency medical services" means the office of emergency medical services within the department of health; and

(7) "Total transports" means all transports reported during the base period by a provider to the office of emergency medical service.

71-5-1503.

(a) An ambulance provider shall pay an assessment to the bureau:

(1) In accordance with this part;

(2) In the amount designated in § 71-5-1504;

(3) Quarterly, on a day determined by the bureau; and

(4) No more than thirty (30) business days after the day on which the bureau issues the ambulance provider notice of the assessment.

(b) The bureau shall:

(1) Determine the standards and procedures used to implement and enforce this part;

(2) Collect the assessment described in subsection (a); and

(3) Transfer assessment proceeds to the state treasurer for deposit into the ambulance service assessment revenue fund created in § 71-5-1507.

(c) An ambulance provider shall not increase charges or add a surcharge to ground transports based on, or as a result of, the assessment described in subsection (a).

71-5-1504.

(a) The bureau shall calculate a uniform assessment per ground transport for each ambulance provider pursuant to subsection (b).

(b) Except as otherwise provided in subsection (c), each quarter of the state fiscal year, the assessment due from each ambulance provider will equal the rate set in subsection (e) multiplied by each provider's transport totals reported from the most recent available completed quarter of transport data recorded by the office of emergency medical services. Ambulance providers will be required to submit a quarterly reporting of all transports to the office of emergency medical services in a manner determined by the office of emergency medical services and the bureau.

(c) In the event that quarterly transport data is not adequate or available for the calculation of assessments, the bureau shall use total transports submitted to the office of emergency medical services for calendar year 2017. The adequacy and availability of the data shall be determined solely by the bureau.

(d) The bureau shall apply any annual changes to the assessment rate, calculated as described in subsection (b), uniformly to all assessed ambulance providers.

(e) The assessment shall generate the lesser of:

(1) Nine dollars and nine cents ($9.09) per each medicaid transport; or

(2) In the event that nine dollars and nine cents ($9.09) per transport causes the statewide assessment to exceed six percent (6%) of statewide net operating revenues, the per transport assessment will equal an amount that shall generate six percent (6%) of statewide net operating revenues.

(f) No more than ninety (90) days after the end of each calendar year, each ambulance provider shall submit revenue reports to the bureau for that entity's most recent fiscal year that ended at least ninety (90) days before this due date.

(g) The comptroller is granted audit authority to test the accuracy of any and all net patient service revenue reports submitted to the bureau for the purposes of this assessment. The comptroller is authorized to impose penalties on providers that do not submit revenue reports, including, but not limited to, fines determined by the comptroller.

71-5-1505.

(a) Upon approval by the centers for medicare and medicaid services of the assessment imposed by this part, the bureau shall reimburse each ambulance provider with qualifying ground ambulance service medicaid transports in an amount calculated by the bureau. This calculation will be determined by the bureau's estimate of assessment collections and the resulting available program funding, less an annual amount of seventy-five thousand dollars ($75,000) to offset medicaid administration expenses and an annual amount of eighty thousand dollars ($80,000) to offset administrative expenses for the Tennessee Ambulance Services Association. If less than these amounts is needed to offset the administrative expenses, the bureau shall only deduct the amount needed. The bureau's estimate of assessment collections and the resulting program funding, netting out any amounts for offset administrative expenses, must be divided by the bureau's projected number of medicaid transports. The resulting amounts will be the additional payment amount made for each medicaid transport reported by the MCO's on a quarterly basis. This amount may change from quarter to quarter.

(b) The bureau shall disburse supplemental payments to ambulance providers based on medicaid transports from the base period as determined by the bureau and as authorized by the centers for medicare and medicaid services.

71-5-1506.

(a) The bureau has the authority to create policy measures that ensure the enforcement and compliance of this part. The bureau shall require an ambulance provider that fails to pay an assessment due under this part to pay the bureau, in addition to the assessment, a penalty determined by the bureau. Enforcement measures determined by the bureau shall include, but not be limited to, recoupments, withholds of future payments, and loss of medicaid ID.

(b) The bureau shall require ambulance providers to submit quarterly transport count data for all transports to the office of emergency services within thirty (30) days of the end of the quarter.

71-5-1507.

(a) There is created a special agency account in the state general fund to be known as the "ambulance service assessment revenue fund," referred to in this part as the "fund." The fund shall continue without interruptions and shall be operated in accordance with this section.

(b) Unless otherwise specified in this part, revenue generated from the following sources must be deposited in the fund:

(1) Assessments collected by the bureau under this part;

(2) Penalties collected by the bureau under this part;

(3) Donations to the fund from private sources; and

(4) Investment earnings credited to the fund.

(c) Any fund balance remaining unexpended at the end of a fiscal year carries forward into the subsequent fiscal year and shall not be diverted to the general fund or any other public fund.

(d) Interest accruing on investments and deposits of the fund carries forward into the subsequent fiscal year and shall not be diverted to the general fund or any other public fund.

(e) The state treasurer shall invest the moneys in the fund in accordance with the provisions of § 9-4-603. The bureau shall administer the funds.

(f) Moneys in the fund must not be diverted to the general fund or any other public fund or any other third party, and moneys in the fund may only be used to:

(1) Create supplemental or directed payments for ground ambulance providers; and

(2) Reimburse the amounts designated in § 71-5-1505 for the purpose of administrative expenses.

(g) In the event that this part is rendered invalid and void:

(1) To the extent federal matching is not reduced due to the impermissibility of the assessments, the bureau shall disburse pursuant to subsection (f) the moneys remaining in the fund that were derived from assessments imposed by this part and deposited before the occurrence of the invalidating event; and

(2) Following disbursement of moneys in the fund pursuant to subdivision (g)(1), the bureau shall refund any remaining moneys to each ambulance provider in proportion to the amount paid by the respective provider during the most recently completed quarterly payment period.

71-5-1508.

(a) The assessment in this part shall not be implemented until after the bureau receives notice from the centers for medicare and medicaid services that approval for the assessment is granted.

(b) The bureau shall implement this part to the extent that it is not inconsistent with the TennCare II federal waiver or any successor federal waiver.

(c) Within ninety (90) days after the date this part becomes law, the bureau shall determine whether an amendment to the TennCare II waiver or any successor federal waiver is required to implement this part. If the bureau determines that an amendment to the TennCare II federal waiver or any successor federal waiver is necessary, the bureau is authorized to seek any necessary waiver amendment and the assessment in this part must not take effect until the waiver amendment is approved.

(d) The ground ambulance provider assessment established by this part terminates on June 30, 2019.

71-5-1509.

The bureau is authorized to promulgate rules to effectuate the purposes of this part. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. If any provision of this act or its application to any person or circumstance is held invalid, then all provisions and applications of this act shall be invalid and void.

SECTION 3. For the purpose of rulemaking and the submission revenue reports, transports data, and other data necessary to implement this act, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect on July 1, 2018, the public welfare requiring it.

House Insurance and Banking Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 1852 **House Bill No. 1857***

by adding the language "for cause" between the word "denied" and the word "or" in subdivision (b)(3) in SECTION 1.

AND FURTHER AMEND by deleting the language "subsection (a)" in subdivision (c)(1) in SECTION 1 and substituting instead the language "subsection (b)".

AND FURTHER AMEND by deleting the language "thirty (30)" in subdivision (c)(2) of the amendatory language of SECTION 1 and substituting instead the language "sixty (60)".

AND FURTHER AMEND by deleting the language "and act" in subdivision (f)(1) of the amendatory language of SECTION 1 and substituting instead the language "while acting".

AND FURTHER AMEND by deleting the language "Any person" in subdivision (f)(2) in SECTION 1 and substituting instead the language "Any person or entity".

AND FURTHER AMEND by deleting SECTION 2 and substituting instead the following:

SECTION 2. This act shall take effect January 1, 2019, the public welfare requiring it.

House Insurance and Banking Subcommittee Am. #1

Amendment No._____

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Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 2232 House Bill No. 1808*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 9-8-307(a)(1)(O), is amended by deleting the language "§ 56-4-218" and substituting the language "title 56".

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 1, Part 1, is amended by adding the following as a new section:

(a) Claims challenging liability imposed by this title must be brought in the chancery court of Davidson County pursuant to the procedures set out in title 67, chapter 1, part 9.

(b)

(1) The commissioner may, against any person, agency, or company licensed, registered, or permitted by or operating under a certificate of authority issued by the commissioner, or acting in an unlawful capacity that brings such person, agency, or company under the jurisdiction of the commissioner, assess the actual and reasonable costs of the investigation, prosecution, and hearing of any disciplinary action held in accordance with the contested case provisions of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, part 3, in which sanctions of any kind are imposed on that person, agency, or company. These costs may include, but are not limited to, those incurred and assessed for the time of the prosecuting attorneys, investigators, expert witnesses, administrative judges, and any other persons involved in the investigation, prosecution, and hearing of the action.

(2) The commissioner may promulgate rules establishing a schedule of costs that may be assessed pursuant to this section. All rules must be promulgated in accordance with the Uniform Administrative Procedures Act.

(3)

(A) All costs assessed pursuant to this section become final thirty (30) days after the date of a final order of assessment is served.

(B) If the individual or entity disciplined fails to pay an assessment when it becomes final, the commissioner may apply to the chancery court of Davidson County, which shall have jurisdiction over recovery of the costs, for a judgment and seek execution of the judgment.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 1, Part 7, is amended by deleting the part.

SECTION 4. Tennessee Code Annotated, Section 56-2-208(b)(1), is amended by deleting the subdivision and substituting the following:

(1)

(A) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the insurer meets one (1) or more of the requirements set out in subdivisions (b)(2)-(7). However, the commissioner may adopt, by rule pursuant to § 56-2-209(g), specific additional requirements relating to or setting forth:

(i) The valuation of assets or reserve credits;

(ii) The amount and forms of security supporting reinsurance arrangements described in § 56-2-209(g); and

(iii) The circumstances pursuant to which credit will be reduced or eliminated.

(B) Credit shall be allowed under subdivision (b)(2), (b)(3), or (b)(4) only in respect to cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of

domicile or, in the case of the United States branch of a non-United States assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under subdivision (b)(4) or (b)(5) only if the applicable requirements of subdivision (b)(8) have been satisfied.

SECTION 5. Tennessee Code Annotated, Section 56-2-208(b)(6)(A), is amended by redesignating the existing language as subdivision (b)(6)(A)(i) and adding the following as a new subdivision (b)(6)(A)(ii):

(ii) Any information submitted by an assuming insurer who is applying for certification as a reinsurer pursuant to subdivision (b)(6)(A)(i) and any information submitted to the commissioner pursuant to this section or any rule promulgated under this section by an assuming insurer who has been certified as a reinsurer pursuant to subdivision (b)(6)(A)(i) is confidential by law, is not open for inspection by members of the public under § 10-7-503 or § 56-1-602, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties and may share the documents, materials, or other information in accordance with the procedures set forth in § 56-11-108(c)-(f).

SECTION 6. Tennessee Code Annotated, Section 56-2-209(a), is amended by deleting the subsection and substituting the following:

(a)

(1) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of § 56-2-208 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. However, the commissioner may adopt by rule pursuant to subsection (g) specific additional requirements relating to or setting forth:

(A) The valuation of assets or reserve credits;

(B) The amount and forms of security supporting reinsurance arrangements described in subsection (g); and

(C) The circumstances pursuant to which credit will be reduced or eliminated.

(2) The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations under the contract, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution. This security may be in the form of:

(A) Cash;

(B) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(C) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution no later than December 31 of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement; or

(D) Any other form of security acceptable to the commissioner.

SECTION 7. Tennessee Code Annotated, Section 56-2-209, is amended by adding the following as a new subsection:

(g)

(1) The commissioner is further authorized to promulgate rules applicable to reinsurance arrangements described in this subdivision (g)(1) relating to:

(A) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(B) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(C) Variable annuities with guaranteed death or living benefits;

(D) Long-term care insurance policies; or

(E) Other life and health insurance and annuity products as to which the commissioner adopts regulatory requirements with respect to credit for reinsurance.

(2) A rule promulgated pursuant to subdivision (g)(1)(A) or (g)(1)(B) may apply to any treaty containing:

(A) Policies issued on or after January 1, 2015; or

(B) Policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(3) A rule promulgated pursuant to this subsection (g) may require the ceding insurer, in calculating the amounts or forms of security required to be held under rules promulgated under this authority, to use the Valuation Manual adopted by the National Association of Insurance Commissioners (NAIC) under Section 11B(1) of the NAIC Standard Valuation Law, including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

(4) A rule promulgated pursuant to this subsection (g) does not apply to cessions to an assuming insurer that:

(A) Is certified in this state or certified in a minimum of five (5) other states; or

(B) Maintains at least two hundred and fifty million dollars ($250,000,000) in capital and surplus, determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments to such manual that are adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is:

(i) Licensed in at least twenty-six (26) states; or

(ii) Licensed in at least ten (10) states, and licensed or accredited in a total of at least thirty-five (35) states.

(5) The authority to promulgate rules pursuant to this subsection (g) does not limit the commissioner's authority to adopt rules pursuant to subsection (e). All rules under this subsection (g) must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 8. Tennessee Code Annotated, Title 56, Chapter 2, is amended by adding the following as a new part:

56-2-901. Short Title. This part shall be known and may be cited as the "Corporate Governance Annual Disclosure Act."

56-2-902. Purpose and Scope.

(a) The purpose of this part is to:

(1) Provide the commissioner a summary of an insurer or insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework;

(2) Outline the requirements for completing a corporate governance annual disclosure with the commissioner; and

(3) Provide for the confidential treatment of the corporate governance annual disclosure and related information.

(b) Nothing in this part prescribes or imposes corporate governance standards and internal procedures beyond that which is required under applicable law. Notwithstanding this section, nothing in this part limits the commissioner's authority or the rights or obligations of third parties under §§ 56-1-408 - 56-1-413.

(c) This part applies to all insurers domiciled in this state, except for:

(1) Captive insurance companies licensed under the Revised Tennessee Captive Insurance Act, compiled in chapter 13 of this title; and

(2) Risk retention groups licensed under chapter 45 of this title.

56-2-903. Definitions. As used in this part:

(1) "Commissioner" means the commissioner of commerce and insurance;

(2) "Corporate governance annual disclosure" or "CGAD" means a confidential report filed by the insurer or insurance group in accordance with this part;

(3) "Department" means the department of commerce and insurance;

(4) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in § 56-11-101;

(5) "Insurer" has the same meaning as "insurance company" in § 56-1-102, except that "insurer" does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(6) "NAIC" means the National Association of Insurance Commissioners; and

(7) "ORSA summary report" means the report filed in accordance with chapter 11, part 2 of this title.

56-2-904. Disclosure Requirement.

(a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the commissioner a CGAD that contains the information described in § 56-2-906(b). However, an insurer or insurance group that files a CGAD pursuant to § 56-2-906(c) may elect to file the CGAD either no later than June 1 or December 31 of each calendar year. Notwithstanding any request

from the commissioner made pursuant to subsection (c), if the insurer is a member of an insurance group, the insurer must submit the report required by this section to the applicable insurance commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

(b) The CGAD must include a signature of the insurer or the insurance group's chief executive officer or corporate secretary attesting that, to the best of that individual's belief and knowledge, the insurer has implemented the corporate governance practices described in the CGAD and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee of the board.

(c) An insurer not required to submit a CGAD under this part shall do so upon the commissioner's request.

(d)

(1) For the purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, the individual legal entity level, or at a combination of levels depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group shall consider the following criteria in determining the level at which the CGAD should be filed:

(A) The level at which the insurer's or insurance group's risk appetite is determined;

(B) The level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised; or

(C) The level at which legal liability for failure of general corporate governance duties would be placed.

(2) If, subsequent to the initial filing of the CGAD, the insurer changes the level of reporting, the insurer shall explain the reason for the change in the first CGAD filed after the change in level of reporting.

(e) The review of the CGAD and any additional requests for information must be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook adopted by the NAIC.

(f) Insurers providing information substantially similar to the information required by this part in other documents provided to the commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to the commissioner, or as part of any department request or examination, are not required to duplicate that information in the CGAD, but are only required to cross reference the document in which the information is included.

56-2-905. Rules. The commissioner may promulgate rules as are necessary to carry out this part in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

56-2-906. Contents of Corporate Governance Annual Disclosure.

(a) The insurer or insurance group has discretion over the responses to the CGAD inquiries, provided that the CGAD must contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The commissioner may request additional information that the commissioner deems material and necessary to provide the commissioner with a clear understanding of the corporate governance policies, the reporting or information system, or the controls implementing those policies.

(b) Notwithstanding subsection (a), the CGAD must be prepared consistent with rules promulgated pursuant to this part. The rules must be consistent with subsection (c). Documentation and supporting information must be maintained and made available upon examination or upon the request of the commissioner.

(c) Rules promulgated under this part must prescribe separate but suitable corporate governance reporting requirements for any insurer or insurance group that is not admitted to write insurance on a direct basis in any other jurisdiction and is either:

(1) Organized under the Tennessee Nonprofit Corporation Act, compiled in title 48, chapters 51-68; or

(2) Governed by a board of which at least seventy-five percent (75%) of its voting directors receive no more than nominal compensation.

56-2-907. Confidentiality.

(a) Documents, materials, or other information, including the CGAD, in the possession or control of the department that are obtained by, created by, or disclosed to the commissioner or any other person under this part, are recognized as being proprietary and containing trade secrets. All such documents, materials, or other information are confidential by law and privileged, are not subject to public inspection under § 10-7-503 or § 56-1-602, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this section requires the written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other CGAD-related information pursuant to subsection (c) to assist in the performance of the commissioner's official duties.

(b) Neither the commissioner nor any person that receives documents, materials, or other CGAD-related information, through examination or otherwise, while acting under the authority of the commissioner, or with whom the documents, materials, or other information are shared pursuant to this part, are permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a).

(c) In order to assist the commissioner in the performance of the commissioner's regulatory duties, the commissioner:

(1) May, as necessary and upon request, share documents, materials, or other CGAD-related information, including the confidential and privileged documents, materials, or information subject to subsection (a), and including proprietary and trade secret documents and materials, with other state, federal, or international financial regulatory agencies, including members of any supervisory college as set forth in § 56-11-116, and with the NAIC, and with third-party consultants pursuant to § 56-9-108; provided, that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing its legal authority to maintain such confidentiality; and

(2) May receive documents, materials, or other CGAD-related information, including otherwise confidential and privileged documents, materials, or information, and including proprietary and trade-secret information or documents, from regulatory officials of other state, federal, or international financial regulatory agencies, including members of any supervisory college as set forth in § 56-11-116, and from the NAIC, and shall maintain as confidential or privileged any such documents, materials, or information received with notice or the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, or information.

(d) The sharing of information and documents by the commissioner pursuant to this part does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of this part.

(e) No waiver of any applicable privilege or claim of confidentiality in documents, proprietary and trade-secret materials, or other CGAD-related information shall occur as

a result of disclosure of CGAD-related information or documents to the commissioner under this part or as a result of sharing as authorized under this part.

56-2-908. NAIC and Third-Party Consultants.

(a) The commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise part of the commissioner's staff, as may be reasonably necessary to assist the commissioner in reviewing the CGAD and related information or the insurer's compliance with this part.

(b) Any persons retained under subsection (a) are under the direction and control of the commissioner and shall act in a purely advisory capacity.

(c) The NAIC and any third-party consultants are subject to the same confidentiality standards and requirements as the commissioner.

(d) As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that it is free of conflicts of interest and that it has internal procedures in place to monitor compliance with conflicts and to comply with the confidentiality standards and requirements of this part.

(e) A written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this part must contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this part:

(1) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this part;

(2) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials,

or other information and has verified in writing its legal authority to maintain confidentiality;

(3) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the department and that the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner;

(4) A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this part in a permanent database after the underlying analysis is completed;

(5) A provision requiring the NAIC or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(6) A requirement that the NAIC or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this part.

56-2-909. Sanctions. Any insurer failing, without just cause, to timely file the CGAD as required in this part is required, after notice and a hearing, to pay a civil penalty of one hundred dollars ($100) per day for each day of delay, to be recovered by the commissioner, which must be paid into the general fund of this state. The maximum penalty under this section is ten thousand dollars ($10,000). The commissioner may reduce the civil penalty if the insurer demonstrates to the commissioner that imposition of the civil penalty would constitute a financial hardship to the insurer in the commissioner's sole discretion.

56-2-910. Severability. If any provision of this part other than § 56-2-907, or the application of this part to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this part that can be given effect without the invalid

provision or application, and to that end the provisions of this part, with the exception of § 56-2-907, are severable.

SECTION 9. Tennessee Code Annotated, Section 56-3-102, is amended by deleting the section.

SECTION 10. Tennessee Code Annotated, Section 56-6-502(3)(A), is amended by deleting the subdivision and substituting the following:

(A) "Managing general agent" or "MGA" means any person who:

(i) Manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office; and

(ii) Acts as an agent for such insurer, whether known as a MGA, manager, or other similar term, and who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the policyholder surplus in any one (1) quarter or year, as reported in the last annual statement of the insurer, and, related to the business produced, either:

(a) Adjusts or pays claims in excess of ten thousand dollars ($10,000) per claim; or

(b) Negotiates reinsurance on behalf of the insurer;

SECTION 11. Tennessee Code Annotated, Section 56-7-2304, is amended by deleting the section and substituting the following:

The commissioner is authorized to adopt rules applicable to insurance policies and subscriber contracts provided by an insurance company or a nonprofit service corporation on a group or group-type basis establishing reasonable requirements for extension of benefits and determination of claim liability in the event of discontinuance of coverage for nonpayment of premiums or replacement of coverage by another carrier. All rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, and shall provide for any notices required that notice

to the group policyholder or subscriber contract holder are deemed notice to the employee, member, or subscriber. No rule shall require the extension of coverage, except as to policies or contracts issued, altered, or amended after the effective date of the rule.

SECTION 12. Tennessee Code Annotated, Section 56-7-2810(d), is amended by adding the following as a new subdivision:

(3) The commissioner may waive subdivision (d)(2) upon written request by a health insurance issuer that demonstrates to the satisfaction of the commissioner that a waiver would benefit insurance consumers in this state and would strengthen the individual market.

SECTION 13. Tennessee Code Annotated, Section 56-11-101(b), is amended by adding the following as new subdivisions:

( ) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under § 56-11-116(d) to have sufficient significant contacts with the internationally active insurance group;

( ) "Internationally active insurance group" means an insurance holding company system that includes an insurer registered under § 56-11-105 and meeting the following criteria:

(A) Premiums are written in at least three (3) countries;

(B) The percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums; and

(C) Based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars ($50,000,000,000), or the total gross written premiums of the insurance holding company system are at least ten billion dollars ($10,000,000,000);

SECTION 14. Tennessee Code Annotated, Section 56-11-108(a), is amended by deleting the subsection and substituting the following:

(a) Documents, materials, or other information in the possession or control of the department that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to § 56-11-107, and all information reported or provided to the department pursuant to §§ 56-11-103(b)(13)-(15), 56-11-105, 56-11-106, and 56-11-116(d), are confidential by law and privileged, are not subject to § 10-7-503 or § 56-1-602, are not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer or health maintenance organization to which it pertains unless the commissioner, after giving the insurer or health maintenance organization and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, enrollees, providers, shareholders, or the public will be served by the publication thereof, in which event the commissioner may publish all or any part thereof, in the manner the commissioner may deem appropriate.

SECTION 15. Tennessee Code Annotated, Section 56-11-106(a)(2)(A), is amended by adding the language ", exchanges, loans, extensions of credit, or investments" after the word "purchases".

SECTION 16. Tennessee Code Annotated, Section 56-11-116, is amended by adding the following as a new subsection (d):

(d) Group-Wide Supervision of Internationally Active Insurance Groups.

(1)

(A) The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance

with this section. However, the commissioner may also acknowledge that another regulatory official shall serve as the group-wide supervisor if the internationally active insurance group:

(i) Does not have substantial insurance operations in the United States;

(ii) Has substantial insurance operations in the United States, but not in this state; or

(iii) Has substantial insurance operations in the United States and this state, but the commissioner has determined pursuant to the factors set forth in subdivisions (d)(2) and (6) that the other regulatory official is the appropriate group-wide supervisor.

(B) An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

(2)

(A) In cooperation with other state, federal, and international regulatory agencies, the commissioner shall identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state, or the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgement under this subsection (d):

(i) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;

(ii) The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group;

(iii) The location of the executive offices or largest operational offices of the internationally active insurance group;

(iv) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

(a) Substantially similar to the system of regulation provided under the laws of this state; or

(b) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(v) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

(B) However, a regulatory official identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgement of the group-wide supervisor must be made after consideration of the factors listed in subdivisions (d)(2)(A)(i)-(v), and must be made in cooperation with and subject to the acknowledgement of other regulatory officials involved with the supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

(3) Notwithstanding any other law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, the commissioner shall make a determination or acknowledgement as to the appropriate group-wide supervisor for the internationally active insurance group pursuant to subdivision (d)(2) if a material change in the internationally active insurance group results in:

(A) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities; or

(B) This state being the place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group.

(4) Pursuant to § 56-11-107, the commissioner is authorized to collect from any insurer registered pursuant to § 56-11-105 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to § 56-11-105 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group has not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish on the website of the department the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(5) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to:

(A) Assess the enterprise risks within the internationally active insurance group to ensure that:

(i) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(ii) Reasonable and effective mitigation measures are in place;

(B) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(i) Governance, risk assessment, and management;

(ii) Capital adequacy; and

(iii) Material intercompany transactions;

(C) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance;

(D) Communicate with other state, federal, or international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the

confidentiality provisions of § 56-11-108, through supervisory colleges as set forth in this section, or otherwise;

(E) Enter into agreements with or obtain documentation from any insurer registered under § 56-11-105, any member of the internationally active insurance group, and any other state, federal, or international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. The agreements or documentation do not serve as evidence in any proceeding that any insurer or person with an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(F) Engage in other group-wide supervision activities consistent with the authority and purposes enumerated in this section and considered necessary by the commissioner.

(6) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor if:

(A) The commissioner's cooperation complies with the laws of this state; and

(B) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and

cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

(7) The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under § 56-11-105, any affiliate of the insurer, and other state, federal, or international regulatory agencies for members of the internationally active insurance group that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(8) The commissioner may promulgate rules necessary for the administration of this section. All rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(9) A registered insurer subject to this section is liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals, and all reasonable travel expenses.

SECTION 17. The headings to sections and subsections in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 18.

(a) This act, with the exception of Section 8, shall take effect upon becoming a law, the public welfare requiring it.

(b) For the purposes of rulemaking, Section 8 of this act shall take effect upon becoming a law, the public welfare requiring it.

(c) For all other purposes, Section 8 shall take effect January 1, 2019, the public welfare requiring it, and the requirement to file the CGAD shall begin in the 2019 calendar year.

House Insurance and Banking Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

_____

Signature of Sponsor

AMEND Senate Bill No. 1869* **House Bill No. 1935**

by deleting the language "Healthcare providers and healthcare" in subsection (b) of Section 3, and substituting the word "Healthcare".

AND FURTHER AMEND by adding the word "and" at the end of subdivision (b)(1)(C) in Section 3 and by deleting subdivision (b)(1)(D) in Section 3 and renumbering subsequent subdivision accordingly.

AND FURTHER AMEND by deleting the language "or healthcare provider" in subsection (c) of Section 3.

AND FURTHER AMEND by deleting Section 2 of the bill and renumbering subsequent sections accordingly.